TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ULTIMATE PAIN SOLUTIONS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-17-2939-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 5, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ultimate Pain Solutions believe that the claims listed were underpaid as Ace American Insurance Company did not pay the (MAR) Maximum Allowable Reimbursement value for the claims."

Amount in Dispute: $27,049.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In the immediate case the provider has failed to submit any additional documentation or bill-specific substantive explanation with its request for reconsideration. All that was submitted was the original bill with an assertion that Requestor was underpaid. Accordingly, that the request was not complete and fails to satisfy the prerequisite for medical dispute resolution."

Position Summary Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2016 through December 2, 2016	Work Hardening Program CPT Codes 97545-WH and 97546-WH (Total of 180 Hours)	$27,049.40	$6,771.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for work hardening programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1001-Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-Additional payment made on appeal/reconsideration.

- 600-Allwoance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 309-The charge for this procedure exceeds the fee schedule allowance.

Issues

Is the requestor entitled to additional reimbursement for the work hardening program rendered on September 26, 2016 through December 2, 2016?

Finding

The requestor is seeking additional reimbursement of $27,049.40 for a work hardening program rendered to the injured worker from September 26, 2016 through December 2, 2016.

To determine if additional reimbursement is due the division refers to 28 Texas Administrative Code §134.230.

28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required.
(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).
(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."
The requestor billed 977545-WH; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

28 Texas Administrative Code §134.230 (3) states "For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The requestor billed for 180 hours of non-CARF accredited work hardening. Based upon 28 Texas Administrative Code §134.230 (1) and (3), 80% of $64.00 = $51.20. $51.20 X 180 hours = $9,216.00. The respondent paid $2,444.80. The requestor is due the difference between the MAR and amount paid of $6,771.20.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $6,771.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,771.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/28/2017 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812